ADVANCED ORAL AND FACIAL SURGERY OF THE MAIN LINE
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DIPLOMATE, AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY
DIPLOMATE, NATIONAL DENTAL BOARD OF ANESTHESIOLOGY

PATIENT REGISTRATION

Today's Date:_____

PATIENT INFORMATION:

First Name: _____ M.I. _____ Last Name: _____ Nickname: _____
Sex: □ Male □ Female Date of Birth: _____ Age: _____ Social Security #: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Tel. #: _____ Cell #: _____ Email: _____
Driver's License#:_____ State:_____
Nearest relative not living with you: _____ Phone #: _____
School: _____ (□ Full Time □ Part Time) Employer: _____ Bus. Tel. #: _____
Name of Dentist: _____ Phone #: _____
Name of Physician: _____ Phone #: _____
Name of Medical Specialist: _____ Phone #: _____
If a minor, are the parents divorced or separated? □ Yes □ No
If a divorce/separation situation, who has custody for medical decisions? _____
If a divorce/separation, who has custody for medical billing? _____
Have you ever been a patient of our practice? □ Yes □ No Referred By: _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT?

□ Self (Skip to next section) □ Spouse □ Father □ Mother □ Other _____
Name: _____ Date of Birth: _____ Age: _____ Social Security #: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Tel. #: _____ Cell #: _____ Email: _____
Employer: _____ Bus. Tel#: _____
Emergency Contact Name: _____ Bus. Tel#: _____
Driver's License#:_____ State:____ Landlord Name:_____ Phone#:_____
Personal Payment Type: □ Cash □ Check □ Credit Card
May we leave a recorded message regarding your financial responsibilities on your home or cell phones?
□Yes □No

INSURANCE INFORMATION

To ensure that you receive the maximum benefits of your insurance program and to prevent unauthorized use of your benefits, we request you *present your insurance cards and driver's license at time of treatment* (copies will be made for our records).

Dental Insurance Company: _____
Address of Insurance Company: _____
_____
Policy Identification #:_____
Group Name: _____Group #: _____
Name of *Insured*: _____
Date of Birth: _____ SS#:_____
Address of Insured: _____
Employer: _____Bus. Tel. #: _____
Employer Address: _____
Patient Relationship to Insured: _____

Medical Insurance Company: _____
Address of Insurance Company: _____
_____
Policy Identification #:_____
Group Name: _____Group #: _____
Name of *Insured*: _____
Date of Birth: _____ SS#:_____
Address of Insured: _____
Employer: _____Bus. Tel. #: _____
Employer Address: _____
Patient Relationship to Insured: _____

***I certify the above to be correct to the best of my knowledge: _____ (Signature)**

OFFICE FINANCIAL POLICY

1. **Our billing and collection policies are necessary to provide quality health care services to our patients at affordable rates. Copies of your insurance cards and drivers licenses will be made and kept on file.**
2. **If you have no insurance, or you carry an insurance that we do not participate with, charges for services are due and payable at the time services are rendered. The office will not bill for services and does not extend credit for treatment provided. Our participation in major medical and dental insurance plans makes it illegal to offer discounts on established fee schedules. For those insurance plans that we do not participate in, we will be happy to provide an itemized receipt to file with your insurance company.**
3. **As a courtesy to our patients, our office submits insurance claims for those plans in which we participate. YOU ARE DIRECTLY RESPONSIBLE TO THE DOCTOR FOR YOUR ACCOUNT IRRESPECTIVE OF YOUR INSURANCE SCHEDULE. Since insurance companies are legally required to process claims within 30 days, you will be billed for any insurance claims that are outstanding in excess of 60 days. You must provide us with complete insurance information for all carriers whom you are insured at the time of service. The office is not responsible for billing additional claims to carriers we were not aware of at the time service is rendered.**
4. **Because medical and dental insurance is a contract between you and your insurance company, we will not become involved in disputes between you and your insurance company regarding deductible, co-payments, covered services secondary insurance, "usual and customary" charges, etc., other than to provide factual information as necessary.**
5. **Many times the insurance plan require of payment of "co-pays" and "deductibles". There is a legal requirement for the subscriber to pay these fees directly to the provider for treatment. A deposit will be requested at the time of treatment as a credit against these unpaid items. Even if you have double coverage (this is possible if a spouse has insurance coverage), there may still be a portion of the charges that will be your responsibility.**
6. **It is your responsibility to know your insurance policies and benefit limits. We encourage you to contact your insurance company directly to determine limits of your coverage. Insurance companies tend to provide more information to the subscriber than the provider's office. We will be happy to provide the appropriate diagnosis and procedure codes to make your inquiry more accurate. Beware that this "predetermination" is not a guarantee of payment once the claim is filed. You are responsible for payment of any procedures that your insurance carrier deems not a covered benefit, medically necessary or experimental/investigational.**
7. **HMO SUBSCRIBERS: You are responsible for obtaining a referral from your primary care physician prior to any services being rendered. If you do not have a referral for your office visit or treatment, you are responsible for payment in full at the time of service. After submissions of claims to insurance companies, it may become apparent that certain procedures are rejected as non- covered services, even though you had a referral from your primary doctor. It is understood that you are responsible for payment of services no matter what determination your insurance carrier has made.**
8. **This office does not participate in MEDICARE/MEDICAID. As such we cannot submit claims on behalf of MEDICARE/MEDICAID participants. MEDICARE supplemental insurance plans require that a claim be filed and processed by MEDICARE and, as such, may not cover any charges submitted to them. This office is not excluded from participation in MEDICARE under Section 1128 of the Social Security Acts.**
9. **In the event it becomes necessary for your account to be referred to a collection agency or an attorney, the patient or legally responsible party will be assessed the actual collection costs, attorney's fees, and court fees which are incurred and a practice administrative fee. You will be held responsible for the entire balance on the account and any insurance adjustments afforded you due to insurance participation will become null and void. Additionally, we have the right to assess account charges on overdue balances at the rate of 1.5% per month (18% per year) after the initial 60 day grace period.**
10. **Broken appointments are costly to the practice and deny others access to care. Appointment failure or those canceled with less than 24 hours' notice are subject to a $100.00 cancellation fee. This fee is not covered by insurance policies and will be billed directly to the individual responsible for the account.**
11. **Checks returned by your bank are subject to a $50.00 processing fee, bank charges and will subject the account to accrual of late payment fees.**

I have fully read and understand the above policies. I hereby authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and that I will be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. My signature below authorizes the release of any medical, dental or other information necessary to process my claim(s).

***Signature: _____ Please Circle Status:** Patient, Parent or Guardian **Date: _____**

HEALTH HISTORY

Today's Date **Patient's Name** **Birthdate** **Chart # (Office use)**

• ___/___/_____ • _____ • ___/___/_____ #_____

Name of person completing form (if different from patient)) _____ *Relationship to patient* _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information you provide will be kept confidential.

1. Height _____ Weight _____
2. Are you in good health? .....Y N
3. Has there been any change in your general health in the past year? .....Y N
4. Date of last physical exam _____
3. Are you now under a physician's care for a particular problem? .....Y N
   Treating Physician: _____ Phone #: _____
4. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .....Y N

   _____

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Congenital Heart Disease? .....Y N
   - B. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - C. Cardiovascular Disease (High Blood Pressure, Chest Pain/ Angina, Palpitations/ Fibrillation, Heart Attack, Coronary Artery Disease, Heart Murmur, Mitral Valve Prolapse, Heart Surgery, Angioplasty, Stents, Heart Bypass, Pacemaker?) .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough / Bronchitis, COPD, Pneumonia, Tuberculosis, Shortness of Breath, Severe Coughing)? .....Y N
   - E. Neurologic Disorders (Stroke, Seizures, Migraines Epilepsy, Convulsions, Fainting or Dizziness).....Y N
   - F. Mental Health Problems (ADHD, Alzheimer's)?.....Y N
   - G. Blood Disorder (Anemia, Bleeding Tendency, Blood Transfusion)? Do you bruise easily?.....Y N
   - H. Liver Disease (Jaundice, Hepatitis A B,C,D,E)? .....Y N
   - I. Kidney Disease? .....Y N
   - J. Diabetes?.....Y N
   - K. Thyroid Disease (Goiter, Hypothyroid, Tumor)?.....Y N
   - L. Arthritis (which joints)? .....Y N
   - M. Stomach Ulcers or Colitis?.....Y N
   - N. Glaucoma?.....Y N
   - O. Hay Fever, Sinus or Nasal problems? .....Y N
   - P. Skin Diseases .....Y N
   - Q. Infectious Diseases (HIV/AIDS, Herpes Simplex, Cold Sores, Venereal Disease, Lyme) .....Y N
   - R. Cancer or Tumor.....Y N
   - S. Radiation (X-ray) or chemotherapy treatment for Cancer? .....Y N
   - T. Implants or artificial joints anywhere in the body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - U. Any disease, drug or transplant operation that has depressed your immune system?.....Y N
   - V. Clicking of jaw (TMJ) joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)?.....Y N
   - C. Thyroid medications? .....Y N
   - D. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - E. High Blood Pressure or Heart medications (Inderal, Digitalis, Nitroglycerin, Cholesterol Drugs)?.....Y N
   - F. Steroids (Cortisone, etc.)? .....Y N
   - G. Tranquilizers or Anti-depressants? .....Y N
   - H. Insulin or Oral Anti-Diabetic drugs? .....Y N
   - I. Antihistamines or Decongestants?.....Y N
   - J. Weight Reduction pills or diet aids?.....Y N
   - K. Vitamins, Natural remedies (Ginko Biloba, Ephedra, Ginseng, etc) or other supplements? .....Y N
   - L. Are you taking or *have you ever taken* Bisphosphonates (Fosamax, Actonel, Boniva, Aredia, Atelvia**,** Zometia, Bonefos, Reclast) for osteoporosis or therapy for breast cancer or multiple myeloma…. Y N
   - M. Narcotics, Marijuana, Cocaine or other "recreational drugs"?.....Y N
   - N. Sexual Enhancement Drugs? (Viagra, Cialis) .....Y N
   - O. Please **list any and all medications** taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

     _____

     _____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .....Y N
   - B. Penicillins, Cephalosporins or other antibiotics?.....Y N
   - C. Sulfa Drugs?.....Y N
   - D. Sedatives, Barbiturates?.....Y N
   - E. Aspirin, NSAIDS, Ibuprofen, or other pain meds?...Y N
   - F. Codeine or other pain killers? .....Y N
   - G. Latex or Rubber Products?.....Y N
   - H. Soy, Egg or Egg Products?.....Y N
   - I. Other allergies or reactions? Please, list.....Y N

     _____
10. Do you smoke or chew Tobacco?.....Y N
    How much per day? _____ Number of Years _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Have you had any serious problems associated with any previous dental treatment?.....Y N
13. Have you required antibiotics prior to dental treatment due to a medical or surgical condition?..... Y N
14. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
15. Do you wish to talk to the doctor privately about anything? .....Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant?.....Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Doctor's Initials: _____ Date: _____

AUTHORIZATION:

I understand that providing incorrect information can be dangerous to my health. I realize the importance of providing true and accurate information about my general health, allergies, medications – including holistic medications, herbal remedies and over-the-counter medicines – and history of drug or alcohol use. I certify that I have read and understand to the best of knowledge the above information, have accurately answered the above questions and have fully informed the doctor of all aspects of my health history, recognizing that if I misinform my doctor the consequences may be life-threatening or may otherwise adversely affect the result of my surgery. I have had the opportunity to discuss my Health History with my doctor.

***** Signature of Person Completing Health History:_____

HIPAA PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing you rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction if it interferes with the delivery of health care or processing of insurance claims, but if we do, we shall honor this agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. I authorize the surgeon to release any information including diagnosis and the records of any examination or treatment rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize the release of protected health information from any and all third party insurance companies that you are enrolled with to assist in filing claims. You have the right to revoke this consent, in the form a written statement signed by you, however, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). A detailed description of the HIPAA policy is available for you review in the waiting room.

Please identify any family members or care givers to whom we may discuss your care:

_____

***Signature: _____ Please Circle Status:** Patient, Parent or Guardian **Date:_____**

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Medical Consultation

Date:_____

Physician:_____ Specialty:_____

Physician Address:_____

Physician Phone: Voice:_____ Fax:_____

Results:_____

_____

_____

_____

_____

_____

_____

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